STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135042	A. BUILDING _____ B. WING _____	06/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHAB	210 W LACROSSE AVE COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 90 10:15 am. On 6/14/06 at 11:45 am, the RCM was interviewed regarding the observations of the resident not being assisted with toileting in a timely manner for a resident who required extensive assistance with toileting and had a history of a pressure ulcer on their buttocks. The RCM was also questioned about the lack of clearly defined interventions on the care plan. The RCM stated the resident was to be toileted before and after meals and at bedtime, usually every 2 hours. On 6/14/06 at 2:00 pm, the resident's buttocks were observed with the RCM. The skin on both sides of the buttocks was reddened, but the areas were blanchable to touch. 5. Resident #17 was admitted to the facility on 5/23/06, with diagnoses which included Alzheimer's dementia. According to the resident's admission MDS assessment, dated 6/1/06, the resident was moderately impaired with cognitive skills for daily decision making, required extensive assistance with bed mobility, transfers, dressing and toilet use. The assessment also indicated the resident was incontinent of both bowel and bladder. The resident's "Care Delivery Guide" dated 5/23/06, documented, "Bladder Incontinent briefs (6/14/06); Bowel Incontinent..." The care plan also revealed a problem, dated 6/1/06, which documented, "Bladder Incontinence (frequency): Incontinent." The listed interventions included: "...Provide adult: briefs; Change incontinent	F 315		

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F 315	Continued From page 91 product PRN [as needed]: ac [before meals] & pc [after meals] & hs [hour of sleep]..." The section regarding at which specific intervals during the day to provide assistance documented, "every two hours." On 6/16/06 at 7:35 am, resident #17 was observed receiving assistance with incontinence cares. The resident was then transferred to a wheelchair and taken to the dining room for breakfast. At 9:00 am, the resident was observed in the dining room being assisted with his meal. At 9:35 am, the resident was observed being wheeled from the dining room to the nurse's station. The resident was observed to remain at the nurse's station in his wheelchair until 10:30 am, when 2 CNAs transferred the resident back to bed and provided incontinence care. On 6/16/06 at 7:00 am, the DON was interviewed. The DON was questioned about the lack of a bladder assessment in the resident's record. The DON stated he would try to locate documentation of a bladder assessment for resident #17. On 6/16/06 at approximately 9:00 am, the DON provided the surveyor a "Bladder Data Collection and Assessment," dated 6/15/06. However, a voiding pattern was not provided. 6. Similar findings for residents #14, #10 and #28. The residents were dependent of staff for toileting and were incontinent. The residents' care plans directed staff to check and change the resident "routinely". Resident #14 was observed on 6/16/06 to go almost 4 hours before being provided incontinent care. The resident's incontinent briefs were completely saturated with	F 315		

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F 315	Continued From page 92 urine after the elapsed time period.	F 315 F323	It is the policy of Lacrosse Health and Rehab to ensure an environment as free of accident hazards as is possible.	7/24/06
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility did not ensure residents were not exposed to toxic chemicals. The hazards observed were related to an unlocked cabinet located on the Special Care Unit in the large dining room. This had the potential to affect 100% of residents who resided on the Special Care Unit who were cognitively impaired and mobile. The findings include: On 6/13/06 at 7:50 am, 10:45 am, 1:15 pm and 3:10 pm, and 6/14/06 at 7:45 am, a cabinet located on the Special Care Unit was observed to be unlocked. In the cabinet was a 16 ounce container of glass cleaner that was approximately three fourths full. Review of the label on the container revealed, "Caution avoid contact with skin and eyes." Additionally, there was a 15 oz container of spray disinfectant in the unlocked cabinet. Review of the label on the bottle revealed, "Caution, hazard to humans and domestic animals." On 6/14/06 at 8:00 am, a nurse manager was interviewed. The nurse manager was informed that the cabinet was unlocked with potentially	F 323	To enhance currently compliant operations and under the direction of the administrator and DON, on 7/11/06 the nursing assistants and 7/13/06 the licensed staff and 7/14/06 the environmental services staff will receive in-service training regarding chemicals being left in areas accessible to residents. The training will emphasize that cleaning chemicals can only be in locked cabinets if stored in areas accessible to residents. Because all residents are potentially affected by the cited deficiency, on 7/10/06 the DON made environmental rounds to ensure all cabinets storing chemicals were locked. No other residents were found to be affected. Effective 7/14/06, a quality-assurance program will be implemented under the supervision of the administrator to monitor for chemical safety. The administrator or designee will conduct random environmental rounds to ensure chemicals are stored safely behind locked doors. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 323	Continued From page 93 hazardous chemicals inside and was asked if the cabinet was to be locked. The nurse manager stated that the cabinet should, in fact, be locked. However, approximately 6 weeks prior, during the remodel of the Special Care Unit, the new cabinets were installed and staff were not given keys for the cabinets to lock them. The surveyor informed the nurse manager that there was a set of keys on the shelf next to the hazardous chemicals. The surveyor observed the nurse manager go to the unlocked cabinet, retrieve the keys and lock the cabinet. He then gave one of the keys to the other nurse manager of the Special Care Unit.	F 323 F324	It is the policy of Lacrosse Health and Rehab to provide adequate supervision and assistance to prevent accidents. Resident #5 was placed with 1:1 supervision related to unsteady gait and falls while out of bed. The dining room supervision was increased on the special care unit to better supervise residents during meals. To enhance currently compliant operations and under the direction of the DON, on 7/11/06 the nursing assistants and 7/13/06 the licensed staff will receive in-service training regarding state/federal and facility requirements concerning accident prevention. The training will emphasize implementing interventions to prevent accidents and injuries and providing for supervision of residents during meal times. Because all residents at fall risk and those that eat in the special care unit dining rooms are potentially affected by the cited deficiency, during the week of 7/17/06 the DON will compile a list of all residents with falls in the past three months. All residents on this list will be re-evaluated by the DON to ensure appropriate interventions have been put into place. The supervision provided in the dining rooms on the special care unit has been increased.	7/24/06
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, review of incident reports and staff interview, it was determined the facility failed to provide adequate supervision and/or assistive devices to prevent accidents. This was true for 1 of 18 sampled residents (#5). This resulted in harm for resident #5 when she experienced a fall which resulted in bruising and swelling to the right side of her right cheek requiring an emergency room visit. Resident #5 had four falls from 4/01/06 through 5/25/06 resulting in bruising, lacerations and abrasions. Additionally, the facility failed to provide supervision in the dining rooms on the	F 324		

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F 324	Continued From page 94 Special Care Unit to prevent resident to resident physical contact, contamination of resident food and contamination of clean linens. This was true for all residents who ate meals in the dining rooms on the Special Care Unit. Findings include: 1. Resident #5 was admitted to the facility on 5/28/03 with diagnoses of fractured humerus, syncope, hypertension and dementia. The annual MDS dated 8/12/05, identified resident #5 for the following: short amd long term memory problems; memory recall ability- location of own room, staff names/faces; cognitive skills for daily decision making- modified independence-some difficulty in new situations only; walking in room and corridor-independent-no help or oversight; balance while sitting and standing-maintained position as required to test; and accidents-none. The quarterly MDS dated 02/13/06, identified the following changes for resident #5: walking in room and corridor- supervision-oversight, encouragement or cueing provided; balance while standing and sitting-not able to attempt test without physical help; and accidents-fell in past 30 days. The quarterly MDS dated, 4/19/06 identified the following changes for resident #5: cognitive skills for daily decision making- moderately impaired-decisions poor -cues/supervision required; and accidents- fell in past 30 days and fell in past 31-180 days. The Falls Rap Summary, dated 8/17/05, read, "Falls, is independent with ab=mbulation	F 324	Effective 7/21/06, a quality assurance program, was implemented under the supervision of the DON to monitor supervision to prevent accidents. The DON or designee will perform random audits of fall accident and incident reports to ensure interventions are implemented to prevent future falls or injuries. The DON or designee will conduct random audits of the special care unit dining rooms to ensure staff are providing supervision and assistance as necessary. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 324	Continued From page 95 [ambulation], gait and balance are intact. Behaviors include resident putting self on floor if she is mad. Has dementia. Is on an antidepressant. Lanoxin for afib [fibrillation]. No recent falls. No appliances for ambulation. ROM [range of motion] intact. Vison [vision] and hearing intact. See summaries in nurse's notes." The "Fall Assessment: Prevention and Management Plan of Care" completed on 8/17/05 did not document that resident #5 had a history of falls even though the resident was admitted to the facility with a fractured humerus as a result of a fall per conversation with Resident Care Manager (RCM) on 06/15/06 at 11:00 am. The resident care manager also stated that upon admit to the facility, the resident had three bruises, two scabs and three scrapes due to her fall history. Based on the review of the facility's incident and accident reports, the "Fall Assessment: Prevention and Management Plan of Care" was not updated to reflect that the resident had a history of falls until after her third fall in the facility on 5/21/06. There was no Fall Risk Scale Form in the chart that assessed the resident based on history, to assist the facility in planning for risk of falls for the resident. The facility policy titled, "Risk Reduction: Falls and Injuries Program" identified the following procedures: 1. Assess and review risk factors for falls and injuries. a. Review the completed "Fall Risk Assessment: Prevention and Management Plan of Care. 2. Review/evaluate other interdisciplinary assessments. 3. Discuss goals and interventions with resident/family for inclusion in the Interdisciplinary Plan of Care (IPOC). 4. Schedule an IPOC meeting. 5. Implement the	F 324		

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F 324	Continued From page 96 "Fall Risk Assessment: Prevention and Management Plan of Care" based on individual residents needs. 6. Complete the Kardex/Individual Resident Care Plan-A. 7. Communicate interventions during Shift Report and Daily Clinical Rounds to the caregiving team. 8. Provide training to staff as needed. 9. Review and revise Interdisciplinary Plan of Care at subsequent IPOC meeting. 10. Educate resident and family as indicated. Review of facility Incident reports and an interview on 6/15/06 at approximately 11:00 am, with the Resident Care Manager (RCM) of the Special Care Unit regarding resident #5's falls revealed the following: a. The report dated 4/01/06 at 5:15 pm, documented that residents were sitting in the small dining room waiting to be served and called out for staff to tell them that a resident had fallen. Resident #5 was found on the floor in the small dining room bathroom floor lying on her right side with her head up next to the toilet. At 10:15 pm, resident #5 was transported to the emergency room due to having a large bruised area on her right cheek that was tender and swelling. The final disposition documented, "...has history of syncope, falling. Has pacemaker, urine dip and cipro started on 4/04/06-possibly r/t [related to] fall?" The RCM reported that the facility thought that the fall was the result of resident #5 having a urinary tract infection. The intervention that they implemented at that time was that the physician ordered Cipro to treat the urinary tract infection.	F 324		

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F 324	Continued From page 97 b. The report dated 4/19/06, documented, "standing 20 feet from the resident and heard a yelp-turned around. Res [resident] was lying face down with arms folded under-3 lacerations to left orbit. Pressure applied-bleeding stopped. Steri strips applied. Ice pack applied. Tylenol given. Denies pain/discomfort." Interventions after the incident were: 1. had resident use w/c [wheelchair] with personal alarms while oob [out of bed]; 2. alarm while in bed; 3. monitored very close (1:1) most of shift." The final disposition stated, "Res [resident] ambulates I [independently] has dx [diagnosis] of syncope and at times becomes unsteady and falls." The incident report identified that there was an interdisciplinary team review and they indicated the resident refused cares. The RCM stated that after the resident fell, the facility attempted to get the resident to use a wheelchair and alarms, however, the resident refused. The RCM could not show documentation that the resident's "Fall Assessment: Prevention and Management Plan of Care" had been updated to reflect the use of the wheelchair or the alarms to prevent further falls. The interventions that the facility did after the fall on 4/19/06 was to contact the resident's Power of Attorney to discuss the resident's refusal of care to use a wheelchair. The nursing notes dated 4/20/06 stated "...Her daughter is her DPOA [Durable Power of Attorney]. Although res[ident] has episodes of syncope, she continues to walk (and occassionally fall in the facility). Daughter feels she does not want to limit her mother's mobility, even though continuing to ambulate may increase her chances of injury."	F 324		

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F 324	Continued From page 98 There was no evidence the facility increased supervision for Resident #5 (other than a 1:1 for the rest of the shift on which she fell) nor were other interventions implemented, when it was decided that the planned interventions would not be implemented. c. The report dated 5/21/06, documented, "[staff name], activities entered room 609, and found resident #5 on floor sitting in front of rocking chair with chair pad behind her. She had one arm on bed and one arm on the rocking chair. No injuries noted." Interventions after the incident were: "1. resident assisted to where she could be observed; 2. resident directed to walk with hand rails." The final disposition stated, "Res at risk for falls given hx [history]. Family desires res to maintain independence and is aware of risk vs [versus] benefits." The RCM stated that after the fall on 5/21/06 the facility did not attempt any new interventions with the resident. They did approach the resident's DPOA to get them to sign the "Refusal of Care or Treatment" form which a copy was in the resident's chart with a date of 5/20/06. This form stated, "I have been advised the following care or treatment is recommended for me: wheelchair-has poor safety awareness. The nature and purpose of the proposed care or treatment is: decreased likelihood of falls re [related] to unsteady gait and hx of syncope. The possible alternatives to the proposed care or treatment are: let ambulate independently with risk of falling. The risk and possible consequences of refusing to consent to the proposed care or treatment include, but are not limited to, the following: falling with or without	F 324		

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injury. Resident/Patient is unable to make a health care decision because: severe cognitive impairment with poor safety awareness. Has hx of falling prior to admit to facility."

There was no evidence the facility increased supervision for Resident #5 (other than assisting where she could be observed on that day and directing this cognitively impaired resident ed to walk with hand rails) or implemented other interventions to keep her safe.

d. The report dated 5/25/06, documented, "Resident found in courtyard by [staff person's name] who was cleaning tables on the 200 or 500 wing of the facility. Resident was on the grass on hands and knees. Assisted to w/c [wheelchair] by CNA and RN. Taken to room and assisted to bed. Denied pain. Both knees reddened. Small 1/4" abrasion noted on left knee. Able to bear wt [weight]. Interventions after the incident were: removed from courtyard and taken to room." The final disposition stated, "MD notified of orthopedic blood pressure drop. Res high risk for falls r/t hx. Presently being allowed to be independent per family's desires."

The RCM stated that after the fall on 5/25/06 the resident's care plan was updated to reflect that she had a history of falls. That was the only intervention that was mad with no changes to the care plan.

Between the dates of 4/01/06 and 5/25/06, the resident sustained 4 falls. Documentation of all four falls indicated the resident fell while wandering on the Special Care Unit. The resident sustained a 1 1/2 centimeter bruise with swelling

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and tenderness requiring an emergency room visit after the fall on 4/01/06. The resident suffered 3 lacerations on the right sight of her face after the fall on 4/19/06. The fall on 5/21/06 resulted in no injuries to the resident. The fall on 5/25/06 resulted in the resident suffering abrasions to both knees.

2. a. On 6/13 at 12:10 pm, there were 10 residents in the large dining room on the Special Care Unit. Resident #18 and random resident #24 were sitting on the outside with resident #16 sitting in the middle of the half circle table with their lunch meals in front of them. The surveyor observed resident #16 reach over and place her hand into resident #18's lunch plate. The surveyor then observed random resident #24 slap resident #16 on the arm in an attempt to get her to remove her hand from resident #18's lunch plate. Resident #16 removed her hand and resumed eating her lunch. During this exchange the only staff member present was in the hallway retrieving a lunch tray to deliver to another resident. On 6/13/06 from 12:10 pm until approximately 12:30 pm there was only 1 staff member by the dining rooms. He was involved in distributing the lunch trays to the residents so was in and out leaving no staff supervision.

On 6/14/06 at approximately 10:30 am, a staff interview was conducted with the RCM of the Special Care Unit regarding a resident hitting another resident. She was surprised to hear about this incident. When she was asked about the lack of supervision for eating she stated, "There are only so many staff to go around."

b. On 6/13 at 12:20 pm, there were 17 residents

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F 324	Continued From page 101 present in the large dining room on the Special Care Unit. Resident #5 was observed picking up and putting into her mouth a slice of bread that had been served to her for lunch and removing it from her mouth and placing it back on the small plate fromwhich it had been served on. The surveyor then observed resident #5 sliding the small plate that the now contaminated bread was on across the table to random resident #25 who was sitting there. Random resident #25 was then observed to pick up the contaminated bread from the plate and eat it. During this interaction there was only one staff member present and he was in the hallway retrieving a lunch tray to deliver to another resident. On 6/13/06 from 12:10 pm until approximately 12:30 pm there was only 1 staff member by the dining rooms. He was involved in distributing the lunch trays to the residents so was in and out leaving no staff supervision. c. On 6/13/06 at 12:40 pm, there were 6 residents eating lunch in the small dining room on the Special Care Unit. Only one of the six residents had their clothing protector on while they were eating. All of the other clothing protectors were on the table next to the residents plates that they were eating from. There were no staff members in the dining room with the residents and had been none since 12:15 pm. At approximately 12:50 pm, a loud sound was heard coming from the small dining room where there were 6 residents present with no staff present. A staff member went to the small dining room to investigate and the loud sound was the sound of one of the resident's throwing clothing protectors that she had taken from the tables into a stack of clean clothing protectors. After the staff person discovered what the sound was, she walked back	F 324		

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F 324	Continued From page 102 into the large dining room leaving the six residents alone in the small dining room. At approximately 1:00 pm another loud sound was heard coming from the small dining room. The surveyor had observed random resident #26 retrieving dirty cloth napkins from the tables in the small dining room and throwing them into a stack of clean linen on a shelf in the small dining room. A staff member came to investigate the loud sound, however, once again left the room with six residents present. d. On 6/14/06 at 12:50 pm there were 15 residents in the large dining room with one staff person present who was handing out the lunch trays and setting them up for the residents. Another staff person did not assist this staff member until 1:10 pm. e. On 6/14/06 at 12:50 pm, resident #5 was sitting at a table in the small dining room with no staff present. Resident #5 had fallen in the small dining room on 4/01/06 resulting in bruising to her head with no supervision in the small dining room. Residents sitting in the small dining room had to yell for staff to inform them that a resident had fallen. She had a positive history of falling and being difficult to redirect and was one of the residents left unsupervised in the small dining room. There was one staff person present who was handing out the lunch trays and setting them up for the residents rotating between the large and small dining rooms. Another staff person did not assist this staff member until 1:10 pm. At no time was there a staff person assigned strictly to the small dining room. f. Resident #5 and random resident #33 were	F 324		

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F 324	Continued From page 103 observed at a table in the small dining room at 12:50 pm on 6/14/06. An Incident report dated 6/03/06, documented, in the small dining room resident #5 and random resident #33 were involved in a resident to resident encounter. Random resident #33 was trying to take resident #5's clothing protector. There were no staff present in the small dining room to provide supervision. At no time was there a staff person assigned strictly to the small dining room. g. On 6/14/06 at 12:50 pm, resident #16 and #18 were sitting at a table in the small dining room with no staff present. Based on the latest quarterly MDS assessment for resident #16 and #18 both of these residents had been identified as needing supervision-cueing with eating. There were no staff present during the lunch meal to provide these residents with supervision or cueing with eating during any of the observations. At no time was there a staff person assigned strictly to the small dining room. h. On 6/14/06 at 1:15 pm, there were 6 residents remaining in the small dining room. Random resident #26 was observed retrieving the clothing protectors from the two tables and throwing them into a pile of clean clothing protectors that were on the shelf. At 1:20 pm, random resident #26 was observed throwing the dirty napkins from the tables into another stack of clean linens. There were no staff present during this time. At no time was there a staff person assigned strictly to the small dining room. On 6/15/06 at approximately 1:30 pm, a staff interview was conducted with the RCM regarding the contamination of linens in the small dining	F 324		

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F 324	Continued From page 104 room and the lack of supervision. The resident care manager agreed that the linens had been contaminated so they were all placed in the dirty clothes container. The surveyor reviewed the numerous examples of lack of supervision in the small dining room. When asked about the lack of supervision the resident care manager stated, "There are only so many staff to go around."	F 324 F353	It is the policy of Lacrosse Health and Rehab to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident. To enhance currently compliant operations and under the direction of the DON, on 7/11/06 the nursing assistants and 7/13/06 the licensed staff will receive in-service training regarding state/federal and facility requirements concerning providing necessary care and treatment to meet resident needs. The training will emphasize assistance and supervision with eating, supervision to prevent falls, assistance with toileting and incontinence cares, care and treatment of pressure ulcers, night shift dressing residents and following the resident's plan of care. Please refer to the plan of correction for F241, F318, F314, F315, F324 as the specific cited examples were addressed in these plans of correction. Because all residents are potentially affected by the cited deficiency, the staffing patterns have been reviewed and adjustments made accordingly to ensure resident needs are met as outlined in their plan of care.	7/24/06
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 353		

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F 353	Continued From page 105 Based on observations, record review, staff interviews, family interview, and resident interview, it was determined the facility did not ensure sufficient staffing was provided to meet necessary care and services of residents. The facility did not provide assistance with eating on a timely basis, ensure residents were provide supervision to prevent falls, ensure residents were provided supervision during meals, ensure residents were assisted with toileting or incontinence care in a timely manner, ensure residents were provided appropriate care and treatment of pressure ulcers and ensure residents were provided the care required according to their plan of care. Also, residents were awakened early to be dressed and then placed back in bed by the night shift staff, due to lack of staff to provide the cares on day shift. This impacted 14 of 21 sampled residents (#'s 1, 2, 3, 4, 5, 8, 10, 11, 12, 14, 15, 16, 17 and 18) and 5 of 21 random residents (#'s 23, 27, 28, 31 and 32) whose records were reviewed. The findings include: a. Based on observations and staff interviews, it was determined the facility did not ensure 4 of 18 sampled residents (#'s 5, 14, 16 and 18) and 2 random residents (#'s 23 and 27) were provided care which enhanced their dignity. Residents were awakened and dressed at an early hour for staff convenience, and residents were not provided with personal hygiene care to present a dignified appearance. Staff reported, "The night shift, each morning around 5:00 am or so, gets 2-3 residents dressed and puts them back to bed as a courtesy to the day shift." Please refer to F241 as it relates to residents not provided dignity.	F 353	Effective 7/17/06, a quality assurance program was implemented under the supervision of the DON to monitor that Resident cares are occurring as outlined in their individualized plan of care. The DON or designee will perform random audits to ensure residents are receiving cares as outlined in their individualized plan of care. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 353	Continued From page 106 b. Based on observation and record review, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality. The facility failed to ensure that physician orders were followed. This was true for 2 of 18 sampled residents (#8 and 14). Based on observations, record review, and staff interview, it was determined the facility failed to ensure a resident who required the use of a splint to his right wrist due to contractures, had the splint in place in accordance with the resident's plan of care and physician orders. This was true for 1 of 18 sampled residents (#4). Please refer to F281 and F318 as it relates to the facility's failure to ensure physician orders were being followed. c. Based on observation, resident, family and staff interview, and record review, it was determined the facility did not ensure consistent preventive measures were implemented for residents at risk for developing pressure ulcers. The facility also failed to ensure ongoing complete and measurable documentation of current pressure ulcers. This was true for 6 of 21 sampled residents (#'s 3, 4, 12, 14, 15 and 17). Please refer to F314 as it relates to pressure ulcer care and prevention. d. Based on observation, record review, resident, family and staff interview, it was determined the facility did not ensure residents bladder function and continence status was maintained at the highest practical level of function. This was true for 6 of 18 sampled residents (#'s 3, 4, 10, 12, 14 and 17) who were not offered toileting or checked for incontinence and changed in a timely manner and 1 of 21 random residents (#28). This was	F 353		

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F 353	Continued From page 107 also true for 1 of 21 sampled residents who the facility allowed a Foley catheter to remain in without an appropriate medical indication for its continued use. Please refer to F315 as it relates to the lack of sufficient staff to provide the care residents required related to toileting and incontinence. e. Based on record review, observations, review of incident reports and staff interview, it was determined the facility failed to provide adequate supervision and/or assistive devices to prevent accidents. This was true for 1 of 18 sampled residents (#5). This resulted in harm for resident #5 when she experienced a fall which resulted in bruising and swelling to the right side of her right cheek requiring an emergency room visit. Resident #5 had four falls from 4/01/06 through 5/25/06 resulting in bruising, lacerations and abrasions. Additionally, the facility failed to provide supervision in the dining rooms on the Special Care Unit to prevent resident to resident physical contact, contamination of resident food and contamination of clean linens. This was true for all residents who ate meals in the dining rooms on the Special Care Unit. When asked about the lack of supervision the resident care manager of the unit stated, "There are only so many staff to go around." Please refer to F324 as it relates to the lack of sufficient staff to provide supervision for prevention of falls and accidents.	F 353		

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F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not ensure sanitary conditions were maintained in the following areas: 1) maintaining proper cold food storage temperatures, 2) food contact surfaces cleaned and sanitized, 3) non-food contact surfaces clean and sanitized 4) proper storage of cold and frozen food items, and 5) ensuring can opener blade was in good operating condition. This had the potential to affect 100 % of the residents who ate in the facility including 18 of 18 sampled residents (#1-18). Findings include: 1. On 6/12/06 at 3:10 pm, during the initial kitchen tour, the thermometer in the walk in cooler indicated it was 51° F. The dietary manager was with the surveyor and indicated the kitchen staff had been in and out of the cooler for dinner preparation and that it had been at the appropriate temperature earlier when the temperatures were recorded. On 6/14/06 at 5:40 am, the walk in cooler temperature was rechecked at a time when the least amount of preparation was occurring to give a more accurate temperature indication. The thermometer in the cooler indicated it was 46° F. The dietary manager was there and indicated it had been 42° F a few minutes earlier. The dietary manager was then asked to check the	F 371	It is the policy of LaCrosse Health and Rehabilitation Center to store, prepare, distribute, and serve food under sanitary conditions. On 6/12/06 the can opener blade was replaced. On 6/13/06 the ice machine was emptied and cleaned. On 6/14/06 the meat slicer was cleaned. On 6/14/06 the reach-in refrigerator was cleaned. On 6/14/06 the oven doors were cleaned. On 6/14/06 the floors were cleaned. On 6/14/06 a technician defrosted the walk-in refrigerator and added a timer to perform a defrost cycle. Food items not at correct temperature were discarded. On 6/12/06 open items in the freezer were closed. All Residents eating in the facility have been identified to potentially be affected by the cited items. However, there are no indications any Residents were affected. To enhance currently compliant operations and under the direction of the Dietary Services Manager, on 6/19/06 and 7/18/06 an in-service training was given to the dietary staff. This training focused on cleaning and proper food storage.	7/24/06

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F 371	Continued From page 109 temperature of a few potential hazardous food products in the cooler. The temperature of some tuna put that was put in the cooler the evening before was at 46° F. A bowl of pudding prepared on 6/13/06 was found to be at 45° F. Some roast beef sandwiches prepared on 6/12/06 were found at 46° F. Those items that were above the required 41° F were thrown out. The dietary manager checked the temperature of all the PHF [potentially hazardous foods] and any that were above 41 °F were discarded. The dietary manager was then asked to provide the temperature logs of the walk in for May and June 2006. * In May 2006 there were 12 morning temperatures and 15 evening temperatures that were above 41° F. The highest recorded temperature was 48° F. This occurred 7 times that month. For this entire month, there was no documentation that indicated the temperature was rechecked after a high temperature was found. There was also no documentation that indicated what the facility did to identify why the temperatures were elevated. *In June 2006 up thru the morning of the 14th, there were 11 morning temperatures and 13 evening temperatures that were above the required 41° F. The highest temperature was 52° F. The evening temperature reached 50° F 5 times and 48° F 6 times. There was no documentation indicating that the temperature were rechecked after a high temperature was recorded. There was also no documentation that indicated the facility investigated as to the cause of the sustained elevated temperatures in the	F 371	The Dietary Services Manager and Registered Dietician will monitor sanitation and food storage by performing audits bi-Monthly. Any deficiencies will be corrected immediately and the audit tools will be submitted at the facilities quality assurance committee meetings for further review or corrective action.	

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F 371	Continued From page 110 walk in cooler. The dietary manager notified a refrigeration company and a technician was sent out. It was found that the compressor for the cooler had frozen over and a timed defrost mechanism was installed for the walk in compressor. Chapter 3, section 501.16(A) of the 2005 FDA Food Code indicates, "Except during preparation, cooking, or cooling, or when time is used as the public health control as specified in section 3-501.19, and except as specified in paragraph (B) of this section, potentially hazardous food shall be maintained:..2(a) 5°C (41°F) or less..." 2. a) On 6/13/06 at 9:00 am the ice machine in the dining room on the 400 hallway was observed to have ice in direct contact with an area of the ice machine that was covered with a slimy black substance. At this time the surveyor wiped a paper towel over the part of the ice machine covered with the substance and visible debris was noted on the paper towel. The outside of the ice machine had dust and lint on top of the controls and the side of the ice machine was dirty showing signs where water had streaked down the side. On 6/13/06 at approximately 9:15 pm, the Director of Nursing was made aware of the dirty ice machine. He stated that the surveyor would need to talk to the maintenance staff person regarding the ice machine. He escorted the surveyor to the maintenance staff person. The maintenance staff person accompanied the surveyor to the ice machine. Upon seeing the black substance in direct contact with the ice, he	F 371		

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F 371	Continued From page 111 agreed that the machine needed to be cleaned. A "do not use" sign was immediately placed on the ice machine to stop further use until it was cleaned. On 6/13/06 at 11:00 am the maintenance staff person showed the surveyor that the ice machine had been cleaned inside. The outside of the ice machine had also been cleaned. The maintenance staff person could not locate a log detailing the last time that the inside of the ice machine had been cleaned. He did show the surveyor a log detailing that the outside was inspected on a monthly basis. The maintenance staff person did agree with the surveyor that the ice machine needed to be cleaned on a regular basis both inside and outside and would begin doing so going forward. b) On 6/14/06 at 5:40 am, a slicer was observed in the kitchen. The front side of the slicer appeared clean and ready for use. However, when the surveyor looked at the back of the slicer and in the spaces and crevices, multiple area with dried food debris were noted. The slicer had been cleaned without taking it apart and cleaning and sanitizing all parts that could come in contact with food. The dietary manager also observed the slicer in this condition and agreed that it was not clean and needed to be taken apart and cleaned and sanitized. Chapter 4, subsection 601.11 of the 2005 Federal Food Code indicates, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch..." 3. On 6/12/06 at 3:10 pm, during the initial kitchen	F 371		

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F 371	Continued From page 112 survey, a free standing refrigerator that was used as a cold beverage storage area during tray line was observed to be dirty. The inside sides and bottom were noted to have multiple drips of fluids and crumbs. The outside doors of the oven were also observed with noted grease deposits and drips on the glass section of the oven doors. The floors were observed to have food debris, dirt and drops of spilt fluids on different sections in the kitchen. At this time the kitchen was in full preparation mode. For this reason these items were investigated at a slower preparation time. On 6/14/06 at 5:40 am, the free standing fridge was again observed to be very dirty with spilled beverages on the inside. The outside handle was also observed to be dirty and covered with a sticky substance. The oven doors contained the same greasy food debris and spillage. The floors were not quite as dirty as the observation before, but still had food debris and spots. These items were shown to the dietary manager. The dietary manager felt that the oven door drip marks were on the inside double pained glass. The surveyor touched the door and felt the dried food debris and verified it was on the outside glass that could be cleaned. The dietary manager acknowledged that the floors were in need of cleaning. Chapter 4, section 601.11 of the 2005 FDA Food Code indicates,"(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Chapter 6, section 501.12 of the 2005 FDA Food Code indicates, "(A) The physical facilities shall be cleaned as often as necessary to keep them clean."	F 371		

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F 371	Continued From page 113 4. On 6/12/06 at 3:10 pm, during the initial kitchen tour, three boxes of frozen fish products and one bag of steak fries were observed stored in the freezer opened and exposed to possible contamination. The dietary manager was notified and acknowledged the items were opened and should be stored closed. Three gallons of milk were observed in the walk in cooler that were opened, but were not dated when they were opened. Chapter 3, section 305.11(A) of the 2005 FDA Food Code indicates, "Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food: (2) Where it is not exposed to splash, dust, or other contamination..." Chapter 3, section 501.17(B), of the 2005 FDA Food Code indicates, "Except as specified in paragraphs (D) and (E) of this section, refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in paragraph (A) of this section; and: (1) The day the original container is opened in the food establishment shall be counted as Day 1..." 5. On 6/12/06 at 3:10 pm, during the initial kitchen tour, the large can opener blade was observed to have the protective coating chipped off of approximately 1/3 of the blade. The chipped off	F 371		

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F 371	Continued From page 114 section of the blade, was the part that does the puncturing. Because of this, the blade was not a smooth cleanable surface for effective sanitation. The dietary manger was shown the blade and acknowledged the protective coating was removed. Chapter 4, section 501.11(A) and chapter 4, section 101.11 of the 2005 FDA Food Code indicates, "Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4.2.." and "Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: (D) Finished to have a smooth, easily cleanable surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition." This is a repeat deficiency from the annual recertification survey of 5/13/05.	F 371		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHAB	210 W LACROSSE AVE COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff, interviews with the local health department, review of facility records, and review of resident records, it was determined the facility failed to provide an infection control program that would ensure that infections were investigated as to their potential cause, ensure that infections were controlled and prevented from spreading to other residents of the facility, and ensure that infections were tracked and reported to the local health department. This affected 3 of 21 sampled residents (#'s 3, 7, and 16), 10 random residents of the facility (#'s 33 through 42) who resided on all of the halls of the facility, 12 employees of the facility and had the potential to affect 100% of residents of the facility. The findings include: 1. a. On 6/14/06 at 9:30 am, a staff member in charge of the facility's infection control program was interviewed. It was reported that several residents of the facility had signs and symptoms of gastrointestinal infections during the past two weeks. The signs and symptoms included	F 441 F441	It is the policy of Lacrosse Health and Rehab to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. To enhance currently compliant operations and under the direction of the DON, on 7/14/06 the infection control nurse will receive in-service training on state/federal and facility requirements regarding the tracking and investigation of gastrointestinal infections. All cited residents were placed on the infection control log during survey and their infections were investigated. The facility medical director was contacted and stated that a "GI bug" was going around the community and the symptoms usually lasted from 1 to 3 days.	7/24/06

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F 441	Continued From page 116 nausea, vomiting, diarrhea, and/or fever. The staff member stated the treatment of the residents with these signs and symptoms was to keep the residents in their rooms, have their meals in their rooms and to notify the residents' physician if the resident had a fever over 101° F, had 2 liquid stools, or complained of nausea and/or vomiting. She stated some labs were done on a few residents with diarrhea which were negative. The staff member also stated the gastrointestinal symptoms started with the first resident on 6/2/06 on the 300 hall and the symptoms lasted for about 3 days. She indicated that gastrointestinal symptoms had been "going around" within the community and it was thought that was where the infections came from. On 6/14/06 at 9:30 am, the surveyor requested a copy of the facility's infection control policies and a list of all residents and employees within the last 2 weeks who had signs and symptoms of gastrointestinal infections. On 6/14/06 at 10:54 am, the local health department official was interviewed and asked if there had been any reports in the area regarding gastrointestinal infections. The individual stated that there had not been any reports of any outbreaks of gastrointestinal infections recently and no reports from any local facilities in the area. On 6/14/06 at 12:45 pm, the surveyors were provided a list of residents and employees who had signs and symptoms of gastrointestinal infections within the last two weeks. The facility provided a list of 13 residents and 12 employees over the course of a 2 week period from 6/2/06 through 6/13/06. The symptoms included nausea,	F 441	Because all residents experiencing gastrointestinal infections are potentially affected by the cited deficiency, during the survey all residents with symptoms were placed on the infection control log with subsequent investigation of the infection. Effective 7/17/06, a quality-assurance Program will be implemented under the direction of the DON to monitor for resident infections. The DON or designee will review the 24-hour reports for any indication of an infectious process and audit the infection control logs and investigations to ensure completion. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 441	Continued From page 117 vomiting, and/or diarrhea lasting anywhere from 1 to 3 days. b. Resident #7 was admitted to the facility on 4/14/06 with the diagnoses of congestive heart failure, asthma, chronic obstructive pulmonary disease, dementia and status post femur fracture. The resident's "Problem Oriented - Progress Notes" (nursing notes) were reviewed and documented the following: *6/6/06 at 10:30 am, "...C/O [complaints of] nausea this am [morning]. States she'd like some alka-seltzer. Fax to MD [and] given 7-Up. nausea did subside [with] carbonated beverage / will observe." At 9:30 pm another entry documented, "...C/O upset stomach this evening before dinner..." *6/7/06 at 10:30 am, "...No c/o gi [gastrointestinal] upset this am but does have large loose BM [bowel movement]..." *6/9/06 at 4:30 am, "...[up] to toilet x [times] [one] had started having BM on mat pulling brief [down] back to bed sleeping [at] this time." At 12:30 pm another entry documented, "...Has diarrhea..." *6/10/06 at 11:00 am, "Afebrile. Resident had 1 x emesis the am [and] diarrhea x 2." At 8:30 pm another entry documented, "Resident has c/o [complained of] not feeling well all shift. She did not eat any dinner this eve [evening] [and] drank very little fluids, had a slight T [temperature] 99.1 Will cont[inue] to monitor." *6/11/06 at 10:00 pm, "Resident has not eaten	F 441		

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F 441	Continued From page 118 any food this shift did drink some fluids [and] a novasource, has been [up and down] in bed serveral times this eve..." *6/12/06 at 10:45 pm, "diarrhea cont refused dinner - c/o upset stomach OOB [out of bed] most of shift. [no] new issues [at] this time." *6/13/06 at 2:50 am, "Resident has had diarrhea this shift. [No] c/o GI upset [no] vomiting noted..." Resident #7's bowel records were reviewed and documented the resident had diarrhea on 6/9, 6/10, 6/11 and 6/12/06. On 6/15/06 at 8:45 am, the DON was asked to provide documentation of when the resident's physician was notified related to the resident's acute GI distress. He returned with the following faxes: "6/6/06, Res c/o nausea (requested alka seltzer) she has no order for Mylanta or anything else for nausea or GI upset. This happened [before] breakfast Fri[day], Mon[day] and today. No emesis, but ref[used] to eat. Did eat other meals. We have had some other Res [with] N/V [nausea and vomiting]." "6/14/06, Res cont to have poor appetite [with] episodes of nausea-Mylanta is helpful, Has had some episodes of diarrhea. Miralax being held since Monday. Diarrhea is less but still has occ [occasional] episodes diarrhea." c. Resident #3 was admitted to the facility on 11/8/01 and re-admitted to the facility on 6/20/04 with diagnoses which included diabetes mellitus	F 441		

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F 441	Continued From page 119 with peripheral neuropathy. Review of resident #3's record revealed the following nurse's notes: *6/2/06 (7:00 am) - "Nausea/vomiting. Diarrhea x [times] 4 since 0600 [6:00 am]. Call to MD et [and] reported to nurse" *6/2/06 (8:30 am) - "New order for Immodium for diarrhea. Reported [increased] T [temperature] to nurse" *6/2/06 (9:00 am) - "Call from [Dr's name] nurse with new orders for labs, UA [urinalysis], CXR [chest x-ray]..." *6/2/06 (1:00 pm) - "Did have emesis p [after] breakfast et continues c [with] nausea/emesis [no] further diarrhea since ac [before meal]. Will try clear liquids for lunch. *6/2/06 (3:00 pm) - "Did keep all of lunch down. T remains [increased]. Remains in room/bedrest." *6/4/06 (11:30 pm) - "Received call from [local laboratory] they stated that 1 of 2 blood cultures drawn on 6/2/06 was 1+ positive for gram + cocci. Call placed to [physician's name] & informed him of positive blood culture & also that he was started on levaquin by the podiatrist [physician's name] stated that's fine for now no new orders will monitor." d. Review of resident #16's record revealed the resident had experienced an increased temperature and diarrhea on 6/5/06 which lasted for one day.	F 441		

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F 441	Continued From page 120 e. Review of the list of 10 random residents (resident #s 33 through 42) revealed the resident experienced signs and symptoms of nausea, vomiting, and/or diarrhea lasting from 1 day to 3 days. f. On 6/14/06 at 12:45 pm, the surveyors were provided a copy of the facility's infection control policies. An "Infection Surveillance" policy was provided. This policy indicated the following: "Infection Criteria (Surveillance Purposes)... Gastrointestinal Tract Infection One of the following criteria must be met: 1. Two or more loose or watery stools above what is normal for the resident in a 24-hour period 2. Two or more episodes of vomiting in a 24-hour period 3. Both of the following: a. A stool culture positive for a pathogen (Salmonella, Shigella, E. coli 0157:H7, Campylobacter) or a toxin assay positive for C. difficile toxin b. At least one symptom or sign compatible with gastrointestinal tract infection (nausea, vomiting, abdominal pain or tenderness, diarrhea)" On 6/14/06 at 1:15 pm, the facility was	F 441		

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F 441	Continued From page 121 questioned as to if the residents who had the gastrointestinal symptoms were investigated, tracked and reported to the local health department. It was reported that this had not been completed, because it was thought that a resident had to experience all 3 of the criteria listed on the policy for the infections to be tracked and reported. However, the facility then received further clarification from their corporate office that they had misinterpreted the policy and that they should have tracked the residents with the gastrointestinal infections and reported the infections to the local health department.	F 441 F444	It is the policy of Lacrosse Health and Rehab to require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. To enhance currently compliant operations and under the direction of the DON, on 7/11/06 the nursing assistants and on 7/13/06 the licensed staff will receive in-service training regarding state/federal/CDC and facility requirements regarding hand washing. The training will emphasize when the use of gloves is required during resident cares as well as when during the course of cares it is required to wash hands. Because all residents requiring staff assistance with activities of daily living are potentially affected by the cited deficiency, the staff will be in-serviced on proper technique. Effective 7/21/06, a quality-assurance program will be implemented under the supervision of the DON to monitor staff hand washing technique during resident cares. The DON or designee will perform random audits of staff during the care process to ensure proper technique is being followed. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	7/24/06
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations and Centers for Disease Control (CDC) guidelines, it was determined the facility did not ensure handwashing was initiated by all staff when caring for residents to prevent the spread of infection. This affected 1 of 18 sampled residents (#4) observed during the provision of personal cares. The findings include: The CDC Guidelines for Handwashing and Hospital Environmental Control 1985, documented the following: "a. Handwashing is the single most important	F 444		

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F 444	Continued From page 122 procedure for preventing nosocomial infections. b. The indications for handwashing probably depend on the type, intensity, duration, and sequence of activity. c...handwashing is indicated, even when gloves are used after situations during which microbial contamination of the hands is likely to occur, especially those involving contact with...body fluids and after touching inanimate sources that are likely to be contaminated... d...handwashing should be encouraged when personnel are in doubt about the necessity for doing so." Resident #4 was admitted to the facility on 8/16/05 with diagnoses which included Alzheimer's disease, coronary artery disease, history of myocardial infarction, and degenerative joint disease. Resident #4 was observed on 6/14/06 at 6:30 am. A CNA was in the resident's room providing incontinence cares. The CNA placed gloves on her hands and cleansed the resident's perineal and buttocks area using a towelette dampened with solution from a spray bottle. With the same potentially contaminated gloves on, the CNA partially dressed the resident, transferred the resident to a wheelchair with the assistance of another CNA using a Hoyer lift, finished dressing the resident, brushed the resident's hair, washed the resident's face and hands with a washcloth, shaved the resident's face, applied aftershave to the resident's face and brushed the resident's teeth. The CNA then removed her gloves and washed her hands. On 6/14/06 at 2:00 pm, 2 other CNAs were	F 444		

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F 444	Continued From page 123 observed providing incontinence care to resident #4. A CNA applied clean gloves, removed the soiled attends, and provided peri-care. With the same potentially contaminated gloves still on, the CNA put a clean incontinence brief on the resident, changed the resident's pants, repositioned the resident on his left side and placed a pillow behind his back. The CNA then removed her gloves and washed her hands. This is a repeat deficiency from the annual recertification survey of 5/13/05.	F 444 F445	It is the policy of Lacrosse Health and Rehab to handle, store, process and transport linens so as to prevent the spread of infection. To enhance currently compliant operations and under the direction of the environmental services director, on 7/11/06 the laundry staff received in-service training. The training emphasized keeping linens being delivered to resident rooms covered to prevent the spread of infection.	7/24/06
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure resident's personal laundry was transported about the facility in a manner to prevent the possible spread of infection. This had the potential to effect all residents whose laundry was processed by the facility. Findings include: On 6/14/06 at 12:13 pm, a laundry cart full of resident's personal laundry was observed being wheeled down the 500 hallway uncovered. The laundry staff member was taking the cart down the hall, stopping from room to room, removing clothes and taking the clothes into the residents' rooms.	F 445	The facility has ordered new covered linen carts for resident's personal laundry for use during delivery to resident rooms. Effective 721/06, a quality-assurance program will be implemented under the direction of the DON to monitor the delivery of linens throughout the facility. The DON or designee will perform random audits to ensure laundry personnel are covering linens when they are being transported throughout the facility. Any deficiencies will be corrected on the spot, and the findings will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 445	Continued From page 124 On 6/14/06 at 12:47 pm, a laundry staff member was observed wheeling an uncovered laundry cart down the 100 hallway. The cart was carrying residents' personal laundry. The cart was then observed being pushed down the 200 hall and over to the 300 hall, making stops along the way and distributing clothes. On 6/14/06 at 11:30 am, the laundry cart full of resident's personal laundry was observed on the Special Care Unit uncovered. Resident's clean personal laundry was being distributed from room to room by the laundry staff member.	F 445		

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F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and observations, it was determined the facility failed to maintain a quality assessment and assurance committee which identified and addressed quality issues, and implemented corrective action plans as necessary. This had the potential to affect 100% of the residents in the facility. Findings include: On 6/16/06 at 9:00 am, a staff interview was conducted with the administrator regarding the	F 520	It is the policy of Lacrosse Health and Rehab to maintain a quality assessment and assurance committee to identify issues with respect to which quality assessment and assurance activities are necessary. To enhance currently compliant operations and under the direction of the DON, on 7/14/06 the members of the quality-assurance committee will receive in-service training regarding the state/federal and facility requirements for the quality assurance committee. The training will emphasize selecting a quality indicator that triggers and reviewing the systems associated with that specific indicator. Because all residents are potentially affected by the cited deficiency, the members of the quality-assurance committee will receive in-service training and with the July, 2006 quality- assurance committee meeting, begin a renewed focus on the quality indicators. The quality–assurance committee meeting minutes will reflect the committees focus, discussion and actions taken to address the selected quality indicator.	7/24/06

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F 520	Continued From page 126 facility's Quality Assurance Committee. During the interview, when the administrator was asked to identify some success stories that the Quality Assurance Committee has had, he referenced the Skin Program. He stated that the facility previously had problems with skin issues and the issues were brought before the Quality Assurance Committee. The Quality Assurance Committee then followed the process by creating and implementing a Skin Program that was operational. He stated the Skin Program on a weekly basis evaluated any skin issues of residents of the facility that were staged I, II, III, or IV. He stated the Quality Assurance Committee Skin Program did not address any skin issues unrelated to pressure ulcers and did not address the prevention of other skin problems. The administrator clarified that the Quality Assurance Committee Skin Program was in addition to the "Wound Prevention and Management" program that was done on the units. During the staff interview on 6/16/06 at 9:00 am, conducted with the administrator regarding the facility Quality Assurance Committee, the surveyor inquired whether the committee had ever addressed the issues the facility had with incontinence and a lack of appropriate toileting programs. The administrator stated, "I will need a nurse to speak to you regarding incontinence issues." He excused himself from the interview in order to locate the DON. When the administrator returned to the interview he stated, "The DON told me the bowel/bladder issues had not tripped as a Quality Indicator for the facility, so the Quality Assurance Committee had not addressed it." He stated the last time that the facility had addressed bowel/bladder issues was in September 2005	F 520		

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F 520	Continued From page 127 when the DON had inserviced the resident care managers. This occurred when the facility corporate office rolled out the corporate wide "Bowel and Bladder Program" that was effective in September 2005. The Quality Indicators for the facility triggered for incontinence, no toileting plan and low risk pressure ulcers. However, the facility did not address these issues and develop and implement an action plan to address these issues. Deficiencies were found related to these Quality Indicators during the survey. Please see F315 and F314 for detailed information regarding these citations.	F 520		

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LACROSSE HEALTH & REHAB	210 W LACROSSE AVE COEUR D'ALENE, ID 83814

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The surveyors conducting the survey were: Nicole Martin, BSN RN, Team Coordinator Kari Head, MS RDLD Diane Miller, LCSW Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocols DON = Director of Nursing CNA = Certified Nurse Aide ADL = Activities of Daily Living LN = Licensed Nurse The following deficiencies were cited during the annual State recertification survey of your facility:	C 000	RECEIVED JUL 17 2006 FACILITY STANDARDS	
C 111	02.100,02,f f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This Rule is not met as evidenced by:	C 111	Please refer to F353	7/24/06

Bureau of Facility Standards

Thomas Holloway — TITLE: Administrator — (X6) DATE: 7/14/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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C 111	Continued From page 1 Refer to F353 as it relates to the facility's failure to provide sufficient staffing to meet necessary care and services of residents.	C 111		
C 124	02.100,03,c,viii viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract; This Rule is not met as evidenced by: Refer to F164 as it addressed resident rights to personal privacy and confidentiality.	C 124	Please refer to F164	7/24/06
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it addressed resident's dignity and respect.	C 125	Please refer to F241	7/24/06
C 129	02.100,03,c,xiii xiii. May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients/residents, and unless medically contraindicated (as documented by his physician in his medical record); and	C 129	Please refer to F252	7/24/06

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C 129	Continued From page 2 This Rule is not met as evidenced by: Refer to F252 as it addressed comfortable and homelike environment.	C 129		
C 168	02.100,12,c c. An incident-accident record shall be kept of all incidents or accidents sustained by employees, patients/residents, or visitors in the facility and shall include the following information: This Rule is not met as evidenced by: Please refer to F 225 as it is related to the investigation of incidents and accidents and for not ensuring thorough screening of potential employees.	C 168	Please refer to F225	7/24/06
C 173	02.100,12,d d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please refer to F157 as it addresses the facility's failure to notify the treating physician of a resident's acute change in medical status.	C 173	Please refer to F157	7/24/06
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards	C 325	Please refer to F371	7/24/06

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C 325	Continued From page 3 for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F 371 as it relates to sanitation during food preparation, storage and service.	C 325		
C 342	02.108,04,b,ii ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 as it addressed accidents specifically the storage of toxic chemicals.	C 342	Please refer to F323	7/24/06
C 361	02.108,07,HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F253 as it relates housekeeping and maintenance services to provide a sanitary and comfortable interior.	C 361	Please refer to F253	7/24/06
C 409	02.120,05,i i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each	C 409	It is the intention of LaCrosse Health and Rehabilitation Center to provide adequate closet space to meet the resident's needs.	7/24/06

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C 409	Continued From page 4 patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on observation and resident and staff interviews, it was determined the facility did not ensure that closet space for each resident measured 20" x 22". This was true for residents living on the 100, 200, 400 and 500 hallways. Findings include: A tour of the environment at the facility with the head of the maintenance department was conducted on 6/16/06 at 8:00 a.m. He indicated the closet space dimensions remained the same from last year with no additions or corrections. Closets in rooms 204, 207, 213, 215, 505, 507, 509 and 513 were very full with the result being that several items of clothing were not accessible due to so many hangers and clothes being hung tightly together in the closet space. Random resident #30 resided in room 204. When she was asked if the surveyor and maintenance staff person could view her closet she stated, "The closet is too small. My clothing is getting ruined as it is just crammed into the small space. Something needs to be done about this." Random resident #29 resided in room 509. The resident was not in her room during the tour with the maintenance man. A resident interview was conducted with her on 6/16/06 at 10:30 am, and she stated, "I get frustrated with the size of my closet. There is only so much room and I try to make do. Most of the time, it is uncomfortable as I cannot have access to all of my clothes that are	C 409	On 7/14/06 a purchase requisition was completed by the Administrator for the purchase of new closets to replace those not meeting the state requirements. The closets not meeting the state requirements have been identified for replacement. The Environmental Services Director will supervise the installation of the new closets and their upkeep.	

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C 409	Continued From page 5 in the closet as it is too full." The administrator was made aware on 6/16/06 at 1:30 pm that the closet waiver would not be extended for the following rooms: 204, 207, 213, 215, 505, 507, 509 and 513, as the residents residing in those rooms were being negatively impacted due to having closet space that was less than the required size.	C 409		
C 644	02.150,01,a,i a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Please refer to F444 as it relates to the facility's failure to ensure employees used proper hand hygiene when caring for residents.	C 644	Please refer to F444	7/24/06
C 663	02.150,02 INFECTION CONTROL COMMITTEE 02. Infection Control Committee. An Infection Control Committee shall be appointed by the administrator which shall: This Rule is not met as evidenced by: Refer to F441 as it relates to reporting requirements related to infection control.	C 663	Please refer to F441	7/24/06
C 671	02.150,03,b b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F445 as it relates to handling of linens to prevent infection.	C 671	Please refer to F445	7/24/06

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C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 as it addressed activities.	C 674	Please refer to F248	7/24/06
C 745	02.200,01,c c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F281 as it relates to standards of nursing practice.	C 745	Please refer to F281	7/24/06
C 778	02.200,03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of care shall be developed in writing upon admission of the	C 778	Please refer to F279	7/24/06

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C 778	Continued From page 7 patient/resident, which shall be: This Rule is not met as evidenced by: Please refer to F279 as it relates to comprehensive care plans.	C 778	See page 8	
C 779	02.200,03,a,i i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F272 as it is related to the provision of complete and accurate assessments.	C 779		7/24/06
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to care plan revisions as needed.	C 782	Please refer to F280	7/24/06 LK
~~C 787~~	~~02.200,03,b,iii~~ iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F311 as it addressed services needed to maintain or improve a resident's abilities.	C 787	See page 8	7/24/06
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2)	C 789		7/24/06

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C 778	Continued From page 7 patient/resident, which shall be: This Rule is not met as evidenced by: Please refer to F279 as it relates to comprehensive care plans.	C 778		
C 779	02.200,03,a,i i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F272 as it is related to the provision of complete and accurate assessments.	C 779	Please refer to F272	7/24/06
C 787	02.200,03,b,iii iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F311 as it addressed services needed to maintain or improve a resident's abilities.	C 787	Please refer to F311	7/24/06
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 as it relates to the facility's failure to prevent an avoidable pressure ulcer.	C 789	Please refer to F314	7/24/06
C 790	02.200,03,b,vi vi. Protection from accident or	C 790		

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C 790	Continued From page 8 injury; This Rule is not met as evidenced by: Refer to F324 as it addressed supervision to prevent accidents and falls.	C 790	Please refer to F324	7/24/06
C 791	02.200,03,b,vii ORAL HYGIENE vii. Oral hygiene; This Rule is not met as evidenced by: Please refer to F312 as it relates to the facility's failure to ensure residents receive oral care.	C 791	Please refer to F312	7/24/06
C 795	02.200,03,b,xi xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please refer to F315 as it is relates to ensuring a resident received the necessary care and treatment to maintain her highest possible bladder function.	C 795	Please refer to F315	7/24/06
C 796	02.200,03,b,xii xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Refer to F318 as it relates to promoting or maintaining physical functioning.	C 796	Please refer to F318	7/24/06